GC WEEKLY INJECTOR/COLUMN CHECK
COCAINE/CODEINE MIX
SYSTEM #:_____YEAR:_____

COLUMN ID: _____

INITIAL AREA: Cocaine: _____

INITIAL COCAINE RT: _____

INITIAL RELATIVE R.T. RATIO (Cocaine/Codeine): _____

DATE INSTALLED:_____

Codeine:_____

INITIAL CODEINE RT: _____

DATE	INITIALS	INJECTION COUNT	AREA COUNT		R.T.
			Cocaine	Codeine	Cocaine

QC COMMENTS:

QC REVIEWER:_____ DATE:_____

QA REVIEWER:_____ DATE:_____

*If the relative R.T. isn't with +/- 5% of the initial value or the area count is less than 50% of the initial value, notify supervisor.

GC WEEKLY INJECTOR/COLUMN CHECK
COCAINE/CODEINE MIX
SYSTEM #:_____YEAR:_____

	RELATIVE R.T.	PERCENT DIFFERENCE	COMMENT
Codeine	Coc./Cod.		

&[FILE]